

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/15/2016
NAME OF PROVIDER OR SUPPLIER PORTER REGIONAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 85 EAST US HWY 6 VALPARAISO, IN 46383		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00200769 Unsubstantiated: lack of sufficient evidence.</p> <p>Date: 6/15/16</p> <p>Facility Number: 005033</p> <p>Porter Regional Hospital, is in compliance with 410 IAC 15-1.5-10, Utilization review & Discharge planning, and 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules.</p> <p>QA: 06-23-16 JL</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE